OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT
FACILITIES DEVELOPMENT DIVISION www.oshpd.state.ca.gov/fdd
1600 9th Street, Room 420 ~ Sacramento, California 95814 Phone (916) 654-3362 FAX (916) 654-2973
1831 9th Street ~ Sacramento, California 95814 Phone (916) 324-9090 FAX (916) 324-9145 (North and Central Region)
311 South Spring Street, Suite 1001, Los Angeles, CA 90013 Phone (213) 897-0166 FAX (213) 897-0168

Plan Review Application Under Annual Building Permit

A

Name of Facility: Email:

Address - Street: Phone: Fax #:

City: County: Zip:

Name of Facility Representative/Administrator: Email:

Address - Street: Phone: Fax #:

City: County: Zip:

Title of Project (45 characters max): Applicant Job #:

B

Description of Project:

Total Licensed Beds:
Before Construction: After Construction:

Type of Project:
❑ Remodel ❑ Repair

Type of Facility:
❑ Gen. Acute ❑ SNF/ICF
❑ Psychiatric Hospital
❑ Correctional Treatment Center

C

Plans and Specifications Prepared By:
Firm/Individual: Reg. #

Address: City: State: Zip:

Phone #: Fax #:

D

Contractor – Firm: State Lic. #: Lic. Class: Exp. Date:

Address: City: State: Zip:

Phone #: Fax #: Contact Person:

E

LICENSED CONTRACTOR'S DECLARATION: I hereby affirm that I am licensed under provisions of Chapter 9 (commencing with Section 7000) of Division 3 of the Business and Professions Code, and my license is in full force and effect.

Contractor's Name: Signature:

F

WORKERS COMPENSATION DECLARATION: I hereby affirm that I have a certificate of consent to self-insure, or a certification of Worker's Compensation insurance, or a certified copy thereof (Section 3800, Labor Code).

Policy #:_____ Copy shall be attached. Date of expiration: _____

Company: _____

Current certified copy has been previously filed with OSHPD ❑ Yes ❑ No

G

ESTIMATED COSTS

1. Estimated construction cost of project (Excluding design fees, inspection fees, and off-site work).....$ _____

H

Name: Phone #:

Address: City: State: Zip:

I certify that I have read this application and state that the above information is correct, and that I am the owner or the duly authorized agent for the owner. I agree to comply with all applicable laws relating to building construction. I hereby authorize representatives of the State of California to enter the above mentioned facility for inspection purposes. If I should become subject to the Worker's Compensation provisions of the Labor Code, I will forthwith comply. In the event I do not comply with the Worker's Compensation law, this approval shall be deemed revoked. I shall also notify OSHPD at least 48 hours prior to the start of any work.

❑ Legal Owner/Administrator

Signature:_____ Date: _____ ❑ Agent for Legal Owner/Administrator

OSHPD #:

Sub Project #

Facility I.D. #:

OFFICE USE ONLY

❑ FR ❑ SR ❑ XR ❑ OR

DISTRIBUTION

❑ OSHPD
❑ Area Compliance Officer
❑ Applicant
❑ Project File
❑ L & C
❑ _____

Test and Inspection Sheet

❑ Attached
❑ Not Required

SPECIAL CONDITIONS:

OSHPD RECEIPT STAMP

PROJECT APPROVAL

Approval of this Project does not authorize or approve any omission or deviation from applicable regulations. Final approval of the work is subject to field inspection. One set of State Agency reviewed plans submitted under this application shall be available on the project site at all times.

Signed-OSHPD Date

THIS APPROVAL EXPIRES IF THE WORK AUTHORIZED IS NOT COMMENCED WITHIN ONE YEAR, OR IS SUSPENDED FOR ONE YEAR.

Reset

OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT
FACILITIES DEVELOPMENT DIVISION www.oshpd.state.ca.gov/fdd
1600 9th Street, Room 420 ~ Sacramento, California 95814 Phone (916) 654-3362 FAX (916) 654-2973
1831 9th Street ~ Sacramento, California 95814 Phone (916) 324-9090 FAX (916) 324-9145 (North and Central Region)
311 South Spring Street, Suite 1001, Los Angeles, CA 90013 Phone (213) 897-0166 FAX (213) 897-0168

INSTRUCTIONS FOR PLAN REVIEW APPLICATION UNDER ANNUAL BUILDING PERMIT (OSH-FD-310)

Do not write in areas designated for "Office Use Only."

A Enter name as it appears on the facility license. Enter email address, street address, city, county, and zip code, phone number and fax number.

Enter the name of the Facility Representative/Administrator, email address, phone number, fax number, city, state, and zip code. Copies of all correspondence will be sent to the Facility Representative/Administrator. If no Facility Representative/Administrator address is entered, copies of all correspondence will be sent to the Facility address as indicated on the license to the attention of the Facility Administrator.

Title of project—enter a brief (45 keystrokes or less) descriptive statement of the work to be performed. Applicants job number—if the facility or architect has a numbering system for projects, enter that project number.

B Description of Project –describe the work to be performed. Where appropriate include square footage and quantities. Enter total licensed bed count before construction and after construction. Check the type of Facility as licensed.

C Provide the name of the architect, engineer or individual in responsible charge of the project, registration number, address, city, state, zip code, phone number and FAX number.

D,E,F

Enter the contractor information if the contractor is known at the time of application. If not known at this time, the information must be provided to OSHPD once the contractor is selected. A separate copy of the application or a copy of the approved application, with Sections C, D, and F completed is sufficient. If Sections D, E, or F of the Annual Building Permit/Application (OSH-FD-306) have previously been filed with OSHPD, Sections E and F of this application need not be completed. Sections D, however, must be completed if a contractor is involved.

G The Annual Building Permit fee is $250.00 for Skilled Nursing Facilities. This fee covers $25,000.00 of estimated construction costs. Calculation of additional fees:

Skilled Nursing Facilities: If the cost of the project or projects constructed under your annual building permit exceeds $25,000.00, you will be assessed an additional fee of 1.5% of the cost over $25,000.00.

The Annual Building Permit fee is $500,00000 for General Acute Care and Psychiatric Hospitals. This fee covers $50,000.00 of estimated construction costs. Calculation of additional fees:

General Acute Care and Psychiatric Hospitals: If the cost of the project or projects constructed under your annual building permit exceeds $50,000.00, you will be assessed an additional fee of 1.64% of the cost over $50,000.00.

OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT
FACILITIES DEVELOPMENT DIVISION www.oshpd.state.ca.us/fdd
1600 9th Street, Room 420 ~ Sacramento, California 95814 Phone (916) 654-3362 FAX (916) 654-2973
1831 9th Street ~ Sacramento, California 95814 Phone (916) 324-9090 FAX (916) 324-9145 (North and Central Region)
311 South Spring Street, Suite 1001, Los Angeles, CA 90013 Phone (213) 897-0166 FAX (213) 897-0168

Estimated Cost—enter estimated construction cost of project including fixed equipment. Exclude all design fees, inspection fees, and off-site work.

H This application is to be signed by the legal owner or administrator of the facility, or their agent. When signed by the agent of the legal owner or administrator, the Letter of Authorization (OSH-FD-309) shall be attached to this application, if not previously filed with the Annual Building Permit/Application (OSH-FD-306).

The application will be returned by OSHPD as an attachment to the Annual Building Permit once the plans and specifications submitted under the application have been reviewed and accepted for construction by OSHPD. Application approval when granted will be noted on the bottom right hand corner of the application.